Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: HARRIS METHODIST 3255 W PIONEER PKWY PANTEGO TX 76013-4620	MFDR Tracking #:	M4-07-4887-01
Respondent Name and Box #: Ace American Insurance Co. Box #: 15		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "This claim has 5 CT scans included on it and they paid a total of $764.84 for all 5 CT scans. We feel that less than $800.00 for all 5 scans to be unacceptable. In 1996 the allowable was $366.00 for each scan. We are asking that this claim be reviewed at that allowable as 'fair and reasonable'. There are 3 of the scans that are billed at over 1,000.00 each and allowing $764.84 for all 5 is just not acceptable we feel."… "We respectfully ask that you reprocess this admit at the Medicare allowable from 1996."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $1073.56
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The Requestor has failed to meet its burden. The file contains no cost breakdowns at all and does not give any cost-basis upon which it can base its bill."… "Respondent asserts it paid a fair and reasonable rate to the Requestor for surgery. Requestor has failed to demonstrate the amount of reimbursement it seeks is fair and reasonable in accordance with the Act. No additional reimbursement is warranted."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/25/2006	147, 45, 112-003, 113-011, 113-031, 113-035, 113, 900, 960-001	Emergency Room Visit	$1073.56	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code 147 – "Provider contracted/negotiated rate expired or not on file."; 45 – "Charges exceed your contracted/legislated fee arrangement.", with additional notation that "Contracted % Discount Reduction: $0.00", and with additional payment advice codes S01 – "Pursuant to Texas Labor Code 413.011 and other applicable statues this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area.", S02 – "Reviewed per applicable State Fee Schedule guidelines.", and S04 – "This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed.", and additional payment advice "The charges have been reviewed by FairPay Solutions Inc. For questions regarding this analysis, contact FairPay Solutions Customer Service at 888-380-5616."; 112-003 – "The primary provider is a non-contracted provider."; 113-011 – "Other import re-pricing completed by FairPay"; 113-031 – "Export/Import re-pricing explanation 1:", with additional payment advice codes S01 – "Pursuant to Texas Labor Code 413.011 and other applicable statues this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area.", S02 – "Reviewed per applicable State Fee Schedule guidelines.", and S04 – "This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed."; 113-035 – "Export/Import re-pricing explanation 5: The charges have been reviewed by FairPay Solutions Inc. For questions regarding this analysis, contact FairPay Solutions Customer Service at 888-380-5616."; 113 – "Any other reduction was determined by the external vendor"; 900 – "Based on further review, no additional allowance is warranted."; and 960-001 – "Repricing per Fair Pay Solutions. For questions call 888-380-5616."
2. This dispute relates to an outpatient emergency room visit and diagnostic radiological services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… This request for medical fee dispute resolution was received by the Division on April 6, 2007. Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
5. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with 134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable". Although the requestor asks for reimbursement "at the Medicare allowable from 1996", review of the documentation finds that the requestor has not provided documentation to support what the Medicare allowable from 1996 would be for all of the services in dispute. Additionally, the requestor has not discussed or demonstrated how payment at the requested rate would meet the requirements of Division rule at 28 TAC §134.1. Review of the documentation finds that the requestor has not discussed how payment of the amount sought is consistent with the criteria of Labor Code §413.011, would ensure similar reimbursement to similar procedures in similar circumstances, is based on nationally recognized published studies, published Division medical dispute decisions, or values assigned for similar work and resource commitments. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(c)(2)(G). Reimbursement cannot be recommended.
6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.